



## PATIENT HEALTH HISTORY

***PLEASE GIVE YOUR INSURANCE CARD & DRIVERS LICENSE TO THE FRONT DESK***

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MALE/FEMALE: \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/ST/ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: M S DW Spouse's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Specialist seen for current problem: \_\_\_\_\_ Phone #: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Last Appt.: \_\_\_\_\_ Phone #: \_\_\_\_\_

We are very willing to work with your other healthcare professionals. Do we have your permission to contact and/or update your other doctors if we feel it will aid in your care? YES \_\_\_\_\_ NO \_\_\_\_\_

Is your condition due to an: Auto Accident: \_\_\_\_\_ Work Accident: \_\_\_\_\_ Other Accident: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

# PERSONAL AND FAMILY HISTORY

Have you or another family member suffered from:

Cancer: Type \_\_\_\_\_ Heart Condition: \_\_\_\_\_ Stroke: \_\_\_\_\_ Diabetes: \_\_\_\_\_

Arthritis: Type \_\_\_\_\_ Other: \_\_\_\_\_

Please list all of the following if applicable:

Accidents: _____	Date(s): _____
Injuries: _____	Date(s): _____
Surgeries: _____	Date(s): _____
Illnesses: _____	Date(s): _____

Date of last:

Physical: \_\_\_\_\_ Blood Work: \_\_\_\_\_ Urine Analysis: \_\_\_\_\_ X-rays: \_\_\_\_\_ MRI: \_\_\_\_\_

Other procedure: \_\_\_\_\_

## HEALTH HABITS:

*How much per day?*

Caffeine (coffee, tea, soda): \_\_\_\_\_ Alcohol: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Hours of Sleep \_\_\_\_\_

Water: \_\_\_\_\_ Exercise: \_\_\_\_\_ Any special diet? \_\_\_\_\_

MEDICATIONS(PRESCRIPTION & OVER THE COUNTER) / SUPPLEMENTS	
1. _____	Reason: _____
2. _____	Reason: _____
3. _____	Reason: _____
4. _____	Reason: _____
5. _____	Reason: _____

*It is our goal to fully understand your wishes regarding your care. Please place an X next to the statement which best fits your goals.*

\_\_\_\_\_ "I only want a consultation and if necessary an examination (2<sup>nd</sup> opinion)"

\_\_\_\_\_ "I am looking for a doctor who can help me using natural healthcare and preventative procedures without the use of medication"

Chief Complaint: \_\_\_\_\_ Cause: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Re-occurring: Y N Degree of Discomfort 1-10(10 worst) \_\_\_\_\_

Description of Discomfort (Sharp, Dull, Burning, Constant, etc.): \_\_\_\_\_

Secondary Complaint: \_\_\_\_\_ Cause: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Reoccurring: Y N Degree of Discomfort 1-10 (10 worst) \_\_\_\_\_

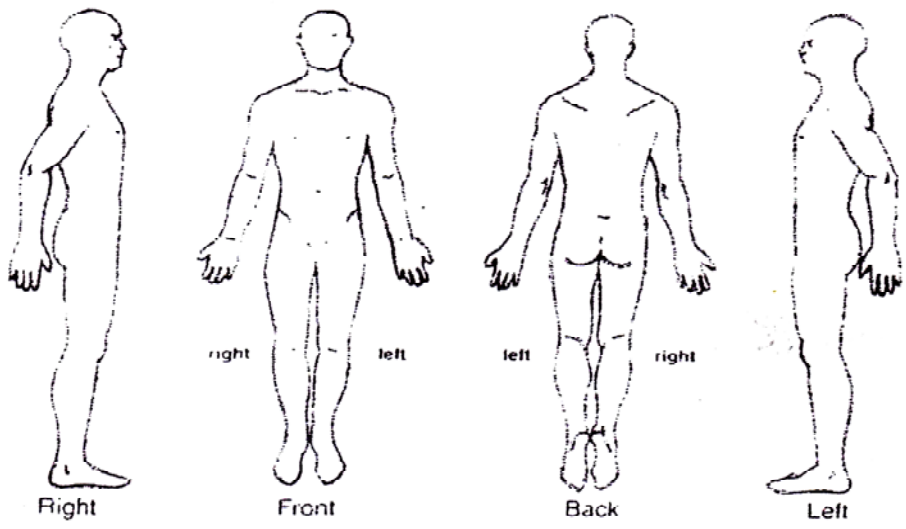
Description of Discomfort: \_\_\_\_\_

Additional Complaint: \_\_\_\_\_ Cause: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Reoccurring: Y N Degree of Discomfort 1-10 (10 worst) \_\_\_\_\_

Description of Discomfort: \_\_\_\_\_

Please draw on the diagram below all areas of discomfort:



Women: Is there any possibility that you could be pregnant? Yes No

Date of last menstrual cycle: \_\_\_\_\_

Place an "X" in the box if you experience any of the following:

<input type="checkbox"/>	lack of mental clarity	<input type="checkbox"/>	arteriosclerosis	<input type="checkbox"/>	trouble walking
<input type="checkbox"/>	fatigue	<input type="checkbox"/>	thrombophlebitis	<input type="checkbox"/>	knee replacement
<input type="checkbox"/>	sweats	<input type="checkbox"/>	TMJ/jaw trouble	<input type="checkbox"/>	hip replacement
<input type="checkbox"/>	weight loss	<input type="checkbox"/>	headaches	<input type="checkbox"/>	neurologic disorder
<input type="checkbox"/>	dizziness	<input type="checkbox"/>	neck pain/stiffness	<input type="checkbox"/>	diabetes
<input type="checkbox"/>	sinus problems	<input type="checkbox"/>	numbness in arms L or R	<input type="checkbox"/>	cancer
<input type="checkbox"/>	asthma	<input type="checkbox"/>	numbness in hands L or R	<input type="checkbox"/>	emphysema
<input type="checkbox"/>	excessive hunger/thirst	<input type="checkbox"/>	pain in arms L or R	<input type="checkbox"/>	thyroid condition
<input type="checkbox"/>	tremors	<input type="checkbox"/>	pain in hands L or R	<input type="checkbox"/>	lung condition
<input type="checkbox"/>	trouble swallowing	<input type="checkbox"/>	elbow problems	<input type="checkbox"/>	liver condition
<input type="checkbox"/>	nausea	<input type="checkbox"/>	wrist problems	<input type="checkbox"/>	venereal disease
<input type="checkbox"/>	stomach pain	<input type="checkbox"/>	shoulder pain	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	constipation/diarrhea	<input type="checkbox"/>	rib pain	<input type="checkbox"/>	mental disorder
<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	low back pain	<input type="checkbox"/>	stroke
<input type="checkbox"/>	urinary problems	<input type="checkbox"/>	disc problems	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	kidney problems	<input type="checkbox"/>	sacral iliac problems		
<input type="checkbox"/>	prostate trouble	<input type="checkbox"/>	sciatica		
<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	leg pain L or R	<input type="checkbox"/>	Females
<input type="checkbox"/>	chronic cough	<input type="checkbox"/>	leg numbness L or R	<input type="checkbox"/>	menstrual problems
<input type="checkbox"/>	chest pain	<input type="checkbox"/>	hip problems	<input type="checkbox"/>	breast problems
<input type="checkbox"/>	difficulty breathing	<input type="checkbox"/>	painful tailbone (coccyx)	<input type="checkbox"/>	menopause
<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	knee problems		
<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	foot problems		
<input type="checkbox"/>	heart condition	<input type="checkbox"/>	wear orthotics		
		<input type="checkbox"/>	pain between the shoulders (mid back region)	<input type="checkbox"/>	other condition

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependent) am responsible for my payments. If I am using insurance coverage, it is with \_\_\_\_\_ and assign directly to Vitalita Chiropractic & Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not it is paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

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**Responsible Party Signature**